INSTITUTE OF PUBLIC HEALTH

COLLEGE OF MEDICINE AND HEALTH SCIENCES

UNIVERSITY OF GONDAR

ASSESSMENT OF PARENT-ADOLESCENT COMMUNICATION AND ASSOCIATED FACTORS ON SEXUAL AND REPRODUCTIVE HEALTH ISSUES AT FAGITA LOKOMA DISTRICT IN AWI ZONE, NORTHWEST ETHIOPIA.

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Assessment of Parent-Adolescent Communication and Associated Factors on Sexual and Reproductive Health Issues at Fagita Lokoma District in Awi Zone, Northwest Ethiopia.

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Examiner

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List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AOR	Adjusted Odds Ratio
ARH	Adolescent Reproductive Health
CI	Confidence Interval
CSWs	Commercial Sex Workers
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IEC	Information Education Communication
MOH	Ministry Of Health
OCP	Oral Contraceptive
COR	Crude Odds Ratio
RH	Reproductive Health
SRH	Sexual and Reproductive Health
SRS	Simple Random Sampling
SPSS	Statistical Package For Social Science.
STI	Sexual Transmitted Infection
USA	United States of America
WHO	World Health Organization

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Abstract

Introduction: The health threats for adolescents today are predominantly behavioral rather than biomedical and more of today's adolescents are involved in health behavior with potential for serious consequence. Parent-adolescent communication on sexual and reproductive health issues remains a challenge in many sub-Saharan African countries including Ethiopia and problems of adolescents are rising from time to time.

Objectives: This study aimed to assess the extent of parent-adolescent communication and associated factors on adolescents' sexual and RH issues at Fagita Lokoma district in Awi Zone, Northwest Ethiopia.

Methods: Institution based quantitative cross-sectional study design and qualitative techniques were conducted among adolescents and selected parents respectively, living in Fagita Lokoma district. A total of 695 in school adolescents aged 13-19 years enrolled in grade 9-12 for the academic year 2011/2012 were selected using multistage sampling technique and selected parents in the community using purposive sampling technique. Six trained data collectors and two supervisors were involved in the data collection process. Pretested anonymous structured self administered questionnaires were used to collect quantitative data among adolescents, which were entered, cleaned using EPI info and analyzed using SPSS version 16.0. Qualitative information was obtained from *f*our focus group discussions among parents. Odds ratio with 95% confidence interval and logistic regression data analysis techniques was employed.

Results: About 50.6% of the adolescents communicated with either of their parents in at least two topics of SRH issues. Educational level of the adolescents, knowledge on contraceptives and perceived openness on communication were significant with parent adolescent communication.

Conclusion and recommendation: The study has shown low level of parent-adolescent communication on SRH issues. Hence sensitize the community to

encourage open communication among family members in general and between parents and adolescents in particular.

1. Introduction

1.1. Statement of the problem

Adolescence is a transitional period from childhood to adulthood, characterized by significant physiological, psychological and social changes WHO define adolescents as those in the age group of 10-19 years(1).

It is both a period of opportunity, a time when new options and ideas as well as a time of vulnerability and risk to different reproductive health problems (2). manual world currently cares for a historic highest number of adolescents; about 1.25 billion adolescents live the world and need proper education, health and other life skills to ensure a better future for themselves and their countries (3). Of these, about 85% live in developing countries. Several countries in Sub-Saharan Africa (SSA) including Ethiopia have large and increasing adolescent populations that exceed those from other parts of the world proportionally (4).

The adolescent population in Ethiopia has been increasing during the last few decades. Currently, adolescents constitute about 25% of the total population. Arranged marriage at an early age is common in most developing countries including Ethiopia (5). In these situations, girls are usually forced to marry an older person without their prior consultation and knowledge. This could result in complicated reproductive health (RH) outcomes. With the advent of HIV and AIDS, this practice is fueling the spread of HIV to adolescents(6).

It has been established in literature that the social and cultural environment of most African communities are governed by ‘culture of silence’ when it comes to discussing sexual issues. This is because some topics are regarded as taboo in African culture (7). The culture of silence created a communication gap between adolescents and their parents in the family and it accounted for the reason why adolescents were punished for misbehaviors and could not question their parents-especially the girls(8).

Adolescents were neither allowed nor encouraged to associate with members of the opposite sex. They were naturally afraid to ask questions relating to sexual issues as they would be seen as “disrespectful” and “disobedient”. Also, sexual issues were regarded as topics for adult discussions only. If a curious adolescent dared to ask a question about his or her sexuality, he or she would either be ignored or insulted (9), (10).

Parent-adolescent communication on sexual and reproductive health issues remains a challenge in many sub-Saharan African countries. As the social milieu in many traditional communities still constrains such communication. Most adolescents do not seem to be comfortable talking about sexuality with their parents (11).

Initiating conversations about sexual and RH issues may also be difficult for parents in such communities as they may be unsure as to how to approach such issues. They may equally doubt their competence in handling sexuality topics and the questions that may be raised by their adolescents or feel confused about the proper amount of information to offer (12).

Therefore a need to conduct research investigating the extent of communication and existing barriers to communicate between adolescents and their parents and also to identify the difficulties experienced by parents in discussing sexual RH issues with their adolescents. The result of this study will also produce information that can be used by program managers and stakeholders in the planning and interventions. Moreover improve awareness of the society for improving activities in the context of prevention of adolescent from sexual and reproductive health challenges such as HIV/AIDS and STIs, early marriage and pregnancy, unwanted/ unintended pregnancy, unsafe abortion and sexual violence.

1.2. Literature review

The health threats for adolescents today are predominantly behavioral rather than biomedical and more of today's adolescents are involved in health behavior with potential for serious consequence (13). The burdens on teenage women are also high. Teenage women are twice as likely to die from pregnancy-related health complications as are women in their twenties. The survey conducted by the central statistical authority, 75.5% was married below 18 years of age. The reproductive and sexual health decisions of these adolescents make today will affect the health and wellbeing of their countries and of their world for decades to come (14).

Although most adults want adolescents to know about abstinence, contraception, and how to prevent HIV and other sexually transmitted diseases (STDs), parents often have difficulty communicating about sexuality (15). Nevertheless, communicating about sexuality is important, positive communication between parents and their children greatly helps adolescents to establish individual values and to make healthy decisions (16). Initiating conversations about the facts of life may be difficult for some parents because they did not grow up in an environment where the subject was discussed. Some parents may be afraid they do not know the right answers or feel confused about the proper amount of information to offer. Moreover, parents were very busy, shy, and were not educated (17).

Many parents does not discuss with their children until they discover their teen has already made difficult sexual related decision. By this time the teen has probably already engaged in sexual activity. The child was not encouraged to discuss sexual related issues from an early age: the teen will feel uncomfortable with the subject matter at this point in time. As the result the teen might lies or tell the parents what they want to hear in order to avoid an awkward situation(3).

Parents most often respond with their hopes that their children will grow into adulthood without unintended pregnancy or a sexually transmitted infection (STI). They sometime follow this with the hope that their adolescents will never be a victim or perpetrator of intimate partner violence or other sexual abuse (18).

Adolescents' reproductive and sexual health is an increasingly important public health priority worldwide. According to the 2006 Mexican national health and nutrition survey, 14.4% of adolescents aged 12–19 have had a sexual relationship; among these, only 63.5% of men and 38% of adolescents women used a condom during their first sexual intercourse(19).

Nationally representative survey of 15- to 17-year-old adolescents in the United States on sexual health communication between teens and their parents conducted. The survey provided a snapshot of teens' views on the subject. 51% of teens (61 % of females; 42 % of males) had discussed with their parents "how to know when you are ready to have sex." 43% of teens (53 percent of females; 33 percent of males) had discussed with their parents how to talk to a boy friend or girl friend about sexual health issues, such as pregnancy, birth control, and STIs (20).

Among male teens, 50 % had discussed condoms, but only 35 % had discussed other forms of contraception. Among female teens, 54 % had discussed condoms and 63 % had discussed other forms of contraception with parents. Overall, 52 % of teens had discussed condoms with their parents; 49 percent had discussed other forms of contraception. 56% of teens (64 percent of females; 48 percent of males) had discussed HIV/AIDS with their parents. 50% of teens (56 percent of females; 44 percent of males) had discussed STIs with parents(21).

According to the Sexuality Information and Education Council of the United States, 93%of adults they surveyed support sexuality education in high school and 84% support it in junior high school. In fact, 88% of parents of junior high school students and 80% of parents of high school students believe that sex education in school makes it easier for them to talk to their adolescents about sex(22). Also, 92% of adolescents report that they want both to talk to their parents about sex and to have comprehensive in-school sex education (23).

A study conducted in China revealed that age, education, family structure, parent's discipline; attitudes towards premarital sex, pattern of communication and dating were significantly associated with youth premarital sex. A relatively large percentage of female adolescents talked to their mothers about sex (33–38%). Only 2% to 8% of males talked to their mothers about sex. Both males and females chose their friends as the person with whom they were most likely to talk about sexual matters (21).

Study conducted in Nigeria revealed 17.9% of parents had no contraceptive knowledge. In a recent survey, 84 percent of women polled indicated that they needed help talking to their children about sex and less than two percent believe parents are doing an excellent job in educating their kids about sexuality (24).

A study done in Uganda the main communication problem faced by adolescent daughters to talk about sexuality to their mothers were 42% reported that they feared their mothers, followed by mothers did not want to talk to them about sexuality 24%, mother were too busy with their work 24%, other reason gives were, the daughter was feeling shy to ask her mother 8%, mothers were not educated 4%. The main communication problem faced by mother was shyness to talk the daughter 68.4%, daughters were stubborn and would not listen to them 34.2%, and mother were very busy 10.5%(25).

An important issue in parent-adolescent communication is determining why parents fail to engage in meaningful discussions with their children. Adolescents are increasingly involved in sexual risk behavior and parents remain one of the important stakeholders in effectively combating this problem (26). Parents are believed to be among the most influential adults who have a deterministic role in the success of interventional programs on adolescents' reproductive health(27). In addition parental monitoring is an important parental factor associated with early sexual activity of adolescents this result is consistent with studies done in different European countries (28)

A study conducted in the USA showed adolescents whose sexual communication with their parents involved more repetition and more new topics felt closer to their parents, felt more able to communicate with their parents in general and about sex specifically, and perceived that discussions with their parents about sex occurred with greater openness than did adolescents whose sexual communication with their parents included less repetition and fewer topics (29).

Another study conducted in Tanzania Communication was triggered by seeing or hearing something a parent perceived negative and would not like their child to experience (such as a death attributable to HIV and unmarried young person's pregnancy(30). Although most young people were relaxed with their mothers than fathers, there is lack of trust as to what they can tell their parents for fear of punishment. Parents were limited as to what they could communicate about SRH because of lack of appropriate knowledge and cultural norms that restricted interactions between opposite sex (31) .

Study conducted in selective region of Ethiopia to assess young people's HIV/AIDS and RH needs in utilization of services revealed that socio-cultural, religious beliefs and sense of morality is the main barrier to young people obtaining adequate RH information. 71.7% of participants agreed that the socio-cultural norm were the major barriers to youth-parent communication(32). 66.2% of participants thought that parents considered discussing RH to young people promoting premarital sex and promiscuity. Due to constraining social norms and taboos, communication between parents and young people is not open(33).

Conceptual Framework

This conceptual framework is prepared by reviewing different literatures. I have made some modifications to relate to my study.

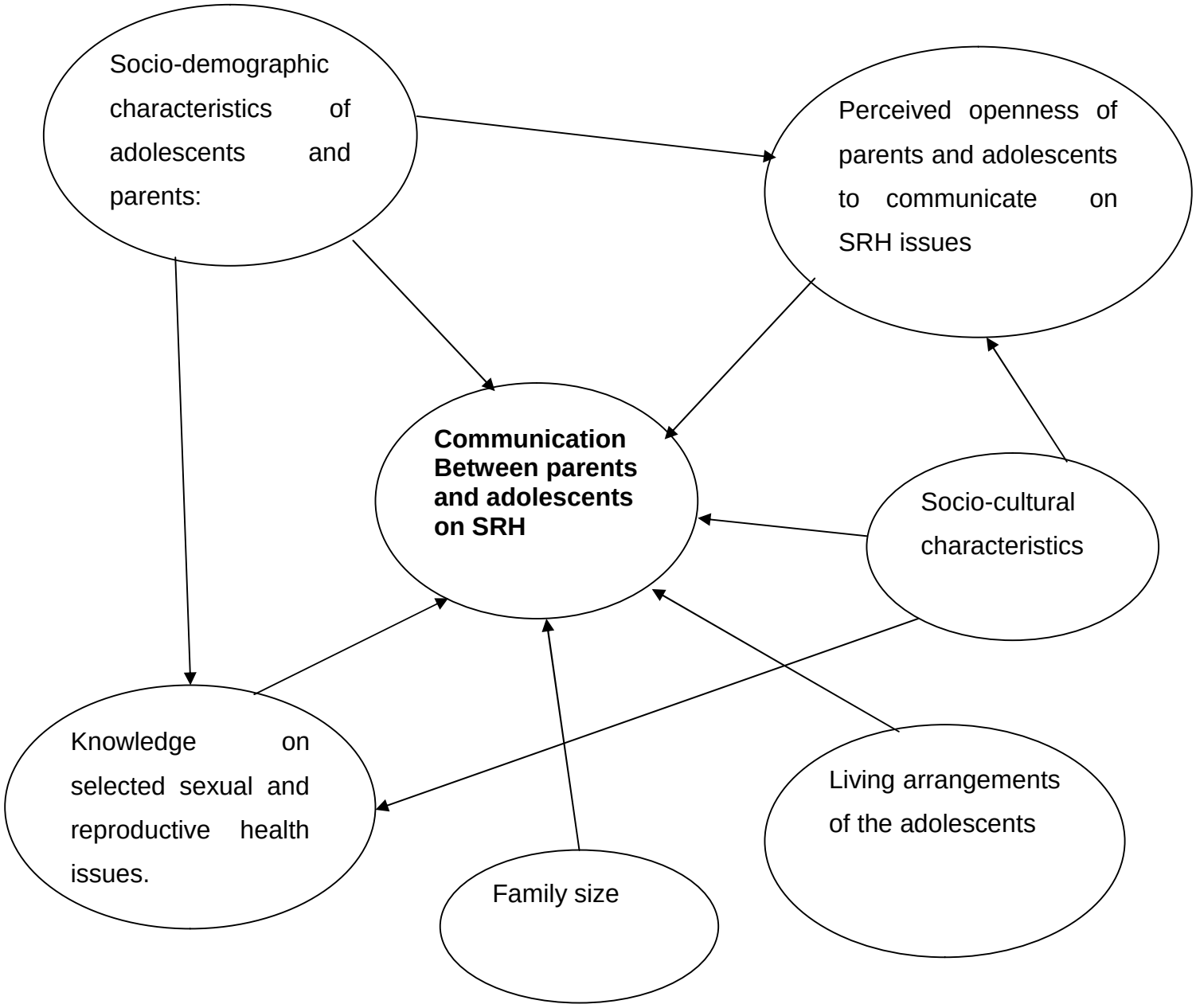

Fig.1 Conceptual frame work of communication between parents and adolescents on SRH (3).

1.3. Justification of the study

Parent-adolescent communication on sexual and reproductive health issues remains a challenge in many sub-Saharan African countries. As the social milieu in many traditional communities still constrains such communication. Most adolescents do not seem to be comfortable talking about sexuality with their parents. Initiating conversations about sexual and RH issues may also be difficult for parents in such communities as they may be unsure as to how to approach such issues. They may equally doubt their competence in handling sexuality topics and the questions that may be raised by their adolescents or feel confused about the proper amount of information to offer.

Therefore a need to conduct research investigating the extent of communication and existing barriers to communicate between adolescents and their parents and also to identify the difficulties experienced by parents in communicating sexual RH issues with their adolescents. The result of this study will also produce information that can be used by program managers and stakeholders in the planning and interventions. Moreover improve awareness of the society for improving activities in the context of prevention of adolescent from sexual and reproductive health challenges such as HIV/AIDS and STIs, early marriage and pregnancy, unwanted/ unintended pregnancy, unsafe abortion and sexual violence.

2. Objectives

2.1. General objective

- To assess the extent of parent-adolescent communication and associated factors on adolescent sexual and RH issues at Fagita Lokoma district in AWI zone.

2.2. Specific objectives

- To determine the extent of parent-adolescent communication on sexual and RH issues.
- To identify factors associated with parent-adolescent communication on sexual and reproductive health issues.

3. Methods

3.1. Study area:

Fagita Lokoma is located in Awi zone, Amhara National Regional State. It is bordered with Dangle woreda a in south ,Banja woreda in north, Mecha woreda in east ,Guangua woreda in southwest directions. Addis kidam is the large town of Fagita Lokoma woreda, which is 104 km away from the capital city of Amhara National Regional State and 460 km away from Addis Ababa. The total area of the woreda estimated to be 597.52 Sq.Km,800-2000m above sea level, temperature,22-26^{0c},climatic condition Dega 55% Wine Dega 45% .According to the data surveyed in 2006/2007, the total population of the woreda is 137,596 (urban, 10,987, and rural 126,606); there are about 69,303 females and 68,293 males. The total number of students in secondary and preparatory school for the academic year 2011/2012 are 3,670, among those 46.27% are males and 53.73% are females. There are about one health center, 6 nucleated health centers, 25 health posts, 5 private clinics of different levels and 8 drug venders. The health service coverage of the woreda is 87.8 %.

3.2. Study design and period:

The study was mixed methods research. Institutional based quantitative cross-sectional study design and qualitative techniques were conducted from April 8 to 21, 2012 G.C.

3.3. Source population:

All adolescents attending class in secondary and preparatory schools of Addis kidam and parents who have adolescents at Fagita Lokoma district were source population.

3.4. Study population:

Samples of adolescents drawn from secondary and preparatory schools of Addis kidam and selected parents who had adolescents at Fagita Lokoma district.

3.5. Inclusion criteria:

All regular students whose age 13 to 19 years attending at Addis kidam secondary and preparatory schools and selected parents who had adolescents age 13-19 years.

3.6.Exclusion criteria:

Students who were absent from class, who had difficulty of communication and selected parents who were mentally ill and had difficulty of communication.

3.7. Sample size:

The required sample size was determined by using single population proportion formula with the following assumptions: Based on a study conducted among high school students of Bullen Woreda Benishangul Gumuz Region, proportion of adolescents who had ever communicated two or more SRH topics with their parents was 28.9%.Level of significance 95%, margin of error 5% and an additional 10% was added as a contingency to increase power and compensate for possible non response.

$$n = \frac{(Z\alpha/2)^2\, p(1-p)}{d^2} * D$$

Where,

n= minimum sample size needed

P= the prevalence of parent-adolescent communication on SRH issue (0.289)

d = marginal error between the sample and population (0.05)

$Z\alpha/2$ = Critical value at 95% confidence interval (1.96)

D = Design effect (2)

$$n = \frac{(1.96)^2\, 0.289\,(1-0.289)}{(0.05)^2} * 2 = 316 * 2 = 632$$

Because of multistage sampling technique, considering the design effect it multiplied by 2 and the calculated sample size was 632.By adding 10% non response rate, the overall sample size was 695.

The above sample size was for the extent of parent-adolescent communication (specific objective). To check whether the sample size calculated was sufficient to assess factors, sample size also calculated for the second specific objective. So, sample size was calculated for some independent variables using EPI Info statistical program for comparison based on two-population proportion (table1)

Table 1: Sample size for each objective

Factor	Assumptions	Sample size
Education level of the adolescents	OR = 2, CI=95%, power = 80, Case to control ratio = 1:1 Proportion of exposure among those who have discussed (50%)	Cases=148 Controls=148 Total = 296
Education status of the mothers	OR = 2, CI=95%, power = 80, Case to control ratio = 1:1 Proportion of exposure among those who have discussed (41.2%)	Cases=144 Controls=144 Total = 288

Number of possible cases that was included in the sample size calculated for the first specific objective was 28.9% * 695 ≈ 201 which was greater than the possible cases included in the sample size calculated for the second specific objective. Therefore, the sample size calculated using single population proportion formula was sufficient to assess factors for parent-adolescent communication.

3.8. Sampling Procedure:

The sampling method was multi stage. The schools consist of grade 9 to 12 and there were sections in each grade labeled as A, B, C, etc. So, the study population was categorized from the source population based on the level of the grade. The number of study subjects included in each grade and school was proportional to their size.

Then sections included in each grade level were selected based on simple random sampling (Lottery method). Adolescents from the selected sections were chosen randomly (computer generated number) and made to fill out the questionnaire in the presence of the data facilitators. Self administered anonymous questionnaires were preferred for this kind of study to minimize social desirability bias and interviewer distortion that often limits the use of face to face interviews.

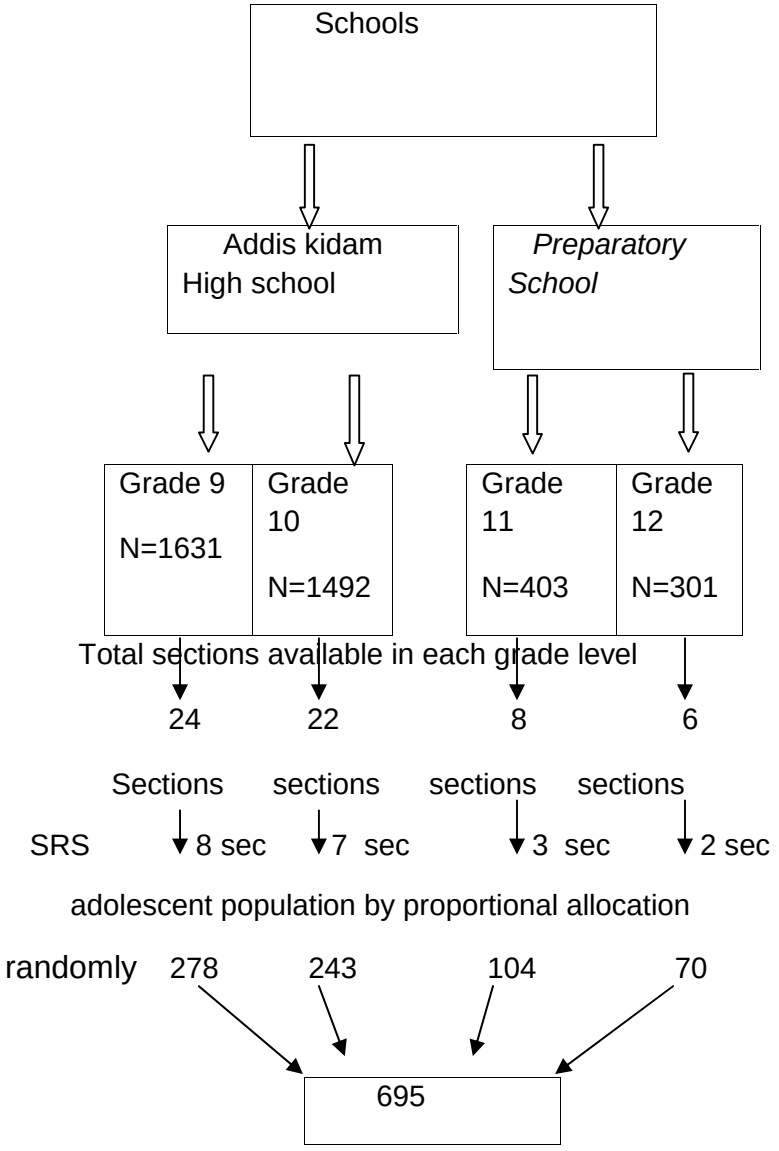

Figure 1: Schematic presentation of sampling procedure.

3.9. Variables

3.9.1.Independent variables

- ✓ Socio-demographic characteristics of adolescents:
  Age, educational level, religion, residence, ethnicity
- ✓ Socio-demographic characteristics of parents
- ✓ Occupation of the parents
- ✓ Educational status of the parents
- ✓ Family size
- ✓ Living arrangements of the adolescents
- ✓ Knowledge on selected sexual and reproductive health issues
- ✓ Socio-cultural characteristics
- ✓ Perceived openness of parents and adolescents to communicate on SRH issues

3.9.2.Dependent variable

- ✓ Communication between parents and adolescents on SRH issues.

3.10. Operational definitions:

- **Parent- adolescent communication on SRH issues**: when adolescents communicated on SRH issues in at least two topics with their parents (about condom, STI/HIV, sexual intercourse, contraceptives, unwanted pregnancy etc.)
- **Communication between parents and adolescents on SRH issues:** in this study context was a simple discussion or talking which was interactive on adolescents SRH issues.
- **Parents:** parents in this study meant biological parents, step parents or foster parents including elder siblings/ guardians.
- **Knowledgeable:** respondents were considered as had good knowledge if they scored more than the average for questions related to SRH issues, if less than the average considered as had poor knowledge.

3.11. Data collection

Data collection tools

3.11.1. Quantitative data

Data were collected using structured self-administrated questionnaire composed of closed-ended questions. The questionnaire was prepared first in English and then translated to Amharic language and finally back to English. The Amharic version questionnaire was pretested for clarity and acceptability. Based on the findings from pre testing, the questions that were difficult to answer were modified and necessary adjustments made prior to the actual study time, then the corrected questionnaires distributed to collect the data.

3.11.2. Qualitative data

A series of four focus group discussions were carried out among purposively selected parents who had adolescents of age 13-19 years. The participants were similar in socio-demographic characteristics. Principal investigator moderated the focus group discussion and two trained nurses took notes. One trained female nurse who took note as well as moderated the female parents to increase the quality of information. Focus group discussions for mothers and fathers were conducted separately to increase the quality of information that generated and ensured the confidence of the respective parents. Tape recorder was used in order to capture their opinion fully after they had been told about the objective of the study and verbal consent obtained. A semi structured questions guideline was used to lead the discussion.

3.12. Data collection procedure:

Six diploma nurses as data collection facilitator ;and a BSc nurse and a health officer as supervisor were assigned and trained. Training was organized and conducted in Amharic language for one day by the principal investigator. The training was focused on objectives of the study, introduction about the questionnaire format, procedures of giving self administered questionnaire to selected respondents after informed consent obtained, guiding them and methods of reporting to supervisor.

The role of the supervisor was to oversee the overall data collection process by data facilitators. The data facilitators distributed the questionnaire to respondents, collected the questionnaires and submitted to the supervisor and then to principal investigator which were rechecked daily for completeness and consistency.

3.13. Data Quality Control:

Questionnaires were pre-tested among 35 students on another public secondary and preparatory school at Dangila Woreda, which is located 21km away from the study area. Training was given for data collectors and supervisors .Principal investigator and supervisors made day to day visit and supervised data collection and handled the questionnaires. At the end of each day, the questionnaires were checked for completeness and consistency and submitted to the principal investigator. Careful note taking, tape recording and transcribing was done for the focus group discussions.

3.14. Data Processing and Analysis:

After data collection, each questionnaire was checked for completeness. Data were coded, entered, cleaned using EPI info and analyzed using SPSS version 16.0. Descriptive statistics, (frequencies, means, and tables and graphs were used). Logistic regression analysis was used to assess the association between dependent and independent variables. Identified strength of associations using odds ratio, 95% CI, was used to assess the associations. A P-value < 0.05 was considered statistically significant in this study. Thematic content analysis was used for the qualitative data.

4. Ethical consideration:

Ethical clearance was obtained from the institute of public health, College of medicine and Health sciences, University of Gondar review board(IRB). Both written and verbal permissions were secured to undertake the study from office of administration and educational office of Fagita Lokoma woreda. After the purpose and objective of the study had been informed, verbal consent was obtained from each study subjects. Participants were also informed that participation was on voluntary basis and they had the right, to refuse filling the questionnaires or withdraw to participate in focus group discussion any time they wanted if they were not comfortable about the study. Moreover during data collection procedure adolescents and selected parents were informed that their answer would remain anonymous and confidential.

5. Results

5.1 Socio-demographic characteristics of respondents:

A total of 695 adolescents responded for the questionnaires, of which 7 were excluded for gross incompleteness and inconsistency. Therefore, analysis was made based on 688 questionnaires making a 98.99% response rate. Just more than half of respondents (51.5%) were females. The mean age of adolescents was 17.5± 1.1 SD years and the range being 6 years (13-19). All the respondents were single. Majority of the respondents (98.1%) were Orthodox Christians. Most of the respondents(82 %) were living in rural area. Five hundred six (73.5%) of the adolescents were Amhara in ethnicity (Table1).

The mean family size of the participants was 5.9. From respondents 83.7% were living with both parents, (62.5%) had illiterate mothers and 77% of the fathers were farmers (Table2).

Table 1: Socio-demographic characteristics of adolescents at Fagita Lokoma District , April 2012 (n=688).

Characteristics	Number	Percent
Age		
13 -16	153	22.2%
17-19	535	77.8%
Sex		
Male	334	48.5%
Female	354	51.5%
Religion		
Orthodox	675	98.1%
Protestant	13	1.9%
Residence		
Urban	124	18%
Rural	564	82 %
Educational status (Grade)		
9	276	40.1%
10	242	35.2 %
11	106	15.4%
12	64	9.3%
Ethnicity		
Amhara	506	73.5%
Agew	182	26.5%
Living arrangements of adolescents:		
With both parents	576	83.7%
With mother	77	11.2%
With father	25	3.6%
Siblings	10	1.5%

Table 2: Socio-demographic characteristics of the parents of adolescents at Fagita Lokoma District , April 2012.

Characteristics	Number	Percent
Marital status of parents		
Married	563	81.8%
Separated	29	4.2%
Divorced	23	3.3%
Widowed	73	10.6%
Mother's ed. Status(n=664)		
Illiterate	430	62.5%
Read and write only	164	23.8%
Primary school	39	5.7%
Secondary school	14	2%
Diploma	8	1.2%
Degree	9	1.3%
Father's ed. Status(n=634)		
Illiterate	267	38.8%
Read and write only	257	37.4%
Primary school	40	5.8%
Secondary school	35	5.1%
Diploma	17	2.5%
Degree	18	2.6%
Mother's occupation (n=664)		
House wife	461	67%
Employed (private)	4	0.6%
Employed (Governmental)	19	2.7%
Small scale merchant	9	1.3%
Farmer (mothers with no husbands)	171	24.9%
Father's occupation(n=634)		
Employed (private)	13	1.9%
Employed (Governmental)	42	6.1%
Small scale merchant	48	7%
Farmer	530	77%
Family size		
<7	557	81%
>7	131	19%

5.2 Knowledge on selected sexual and reproductive health issues.

Five hundred fifty five (80.7%) of the students knew about traditional, natural and modern contraceptive methods. Inject able contraceptives and Pills were mentioned by 424 (61.6%) and 251 (36.5%) respondents respectively (figure1). Six hundred twenty five (90.8%) of the respondents knew about STI/HIV/AIDS.HIV/AIDS was the most commonly known STD 602(87.5%), followed by Gonorrhea 231(33.6%) (figure2). Five hundred forty two(78.8%) respondents knew when first menstrual period started (menarche) in any girl.

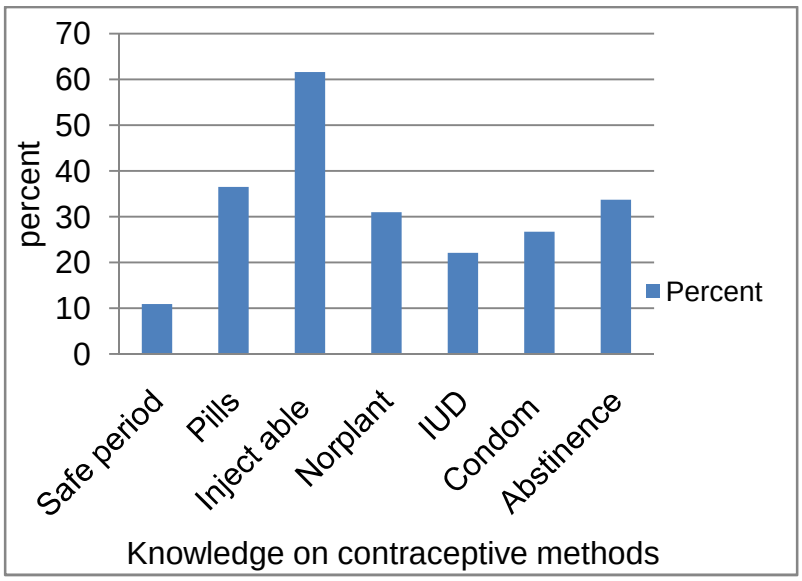

Figure 1: knowledge of adolescents on contraceptive methods at Fagita Lokoma District , April 2012.

- Multiple responses were possible.

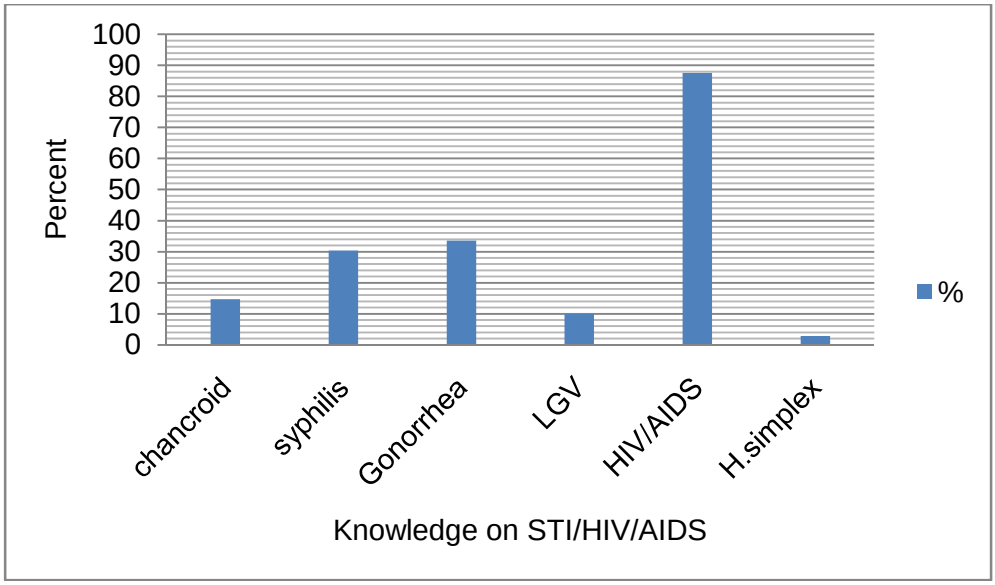

Figure 2 : knowledge of adolescents on HIV and STI at Fagita Lokoma District , April 2012.

- Multiple responses were possible.

5.3 Communications on sexual and reproductive health issues

Five hundred twenty three (76%) respondents agreed that it is important to discuss on sexual and reproductive health issues with parents. Three hundred forty eight (50.6%) of the adolescents communicated with either of their parents in at least two topics of SRH. From those communicated with their parents almost half of the respondents had communicated with their mothers. Out of total adolescents who communicated with either of their parents (348) in at least two topics of SRH, majority (86.9%) had communicated on STI/HIV/AIDS and 58.1% had communicated on contraceptive methods. The remaining13.1% had not communicated on this issue, of them 83.3% were due to culture and 55.6% due to lack of knowledge (Tables 3 and 4). Out of those who communicated on contraceptive methods 66.25%) communicated with their mothers (Tables 3 and 4). Age of adolescents starting communication on SRH issues with their parents, 26(3.8%) by <10 years, 59(8.6%) by 10-13 years , 252(36.6%) by 14-16years and 351(51%) by >16 years.

Table 3 Adolescents communicating with their parents on selected SRH topics, at Fagita Lokoma District , April 2012.

Topic of Communication		With whom they had communicated		
	Yes(%)	Fathers(%)	mothers(%)	Non biological parents(%)
Contraceptive	400(58.1)	96(14)	265(38.5)	9(1.3)
STI/HIV/AIDS	598(86.9)	244(35.5)	330(48)	11(1.3)
Sexual Intercourse	298(43.3)	95(13.8)	164(23.8)	6(0.9)
Unwanted Pregnancy	459(66.7)	120(17.4)	302(43.9)	4(0.6)
Avoiding premarital sex	429(62.4)	139(20.2)	251(36.5)	7(1.0)
Condom	304(44.2)	103(15.0)	140(20.3)	3(0.4)
Pubertal stage	391(56.8)	117(17)	197(28.6)	7(1.0)
Communication on at least two SRH issues	348(50.6)	139(20.2)	302(43.9)	7(1.0)

- Multiple responses were possible

Table 4:**The major reasons for not discussing with their parent in school adolescents , at Fagita Lokoma District , April 2012.**

Topic of communication	N (%)not Communicating	Reason for not communicating							
		Culture*	**Shame***	**knowledge***	**not listener***	**Comm. skill ***	**embarrass***	**don't know***	**Others***
Contraceptive	288(41.9)	29(4.2)	116(16.9)	160(23.3)	43(6.2)	37(5.4)	12(1.7)	7(8.3)	6 (2.0)
STI/HIV/AID	90(13.1)	75(10.9)	64(9.3)	62(9.0)	22(3.2)	28(4.1)	7(1.0)	26(3.8)	7(0.1)
Sexual Intercourse	390(56.7)	111(16.1)	180(26.2)	184(26.7)	51(7.4)	55(8)	18(2.6)	61(8.9)	7(1.0)
Unwanted Pregnancy	229(33.3)	63(9.2)	116(16.9)	151(21.9)	40(5.8)	41(6.0)	15(2.2)	40(5.8)	2(0.3)
Avoiding premarital sex	259(37.6)	73(10.6)	141(20.5)	143(20.8)	40 (5.8)	37 (5.4)	10 (1.5)	45(6.5)	2(0.3)
Condom	384(55.8)	112(16.3)	170(24.7)	203 (29.5)	49 (7.1)	40 (5.8)	5 (2.2)	63(9.2)	0
Pubertal Stage	297(43.2)	73(10.6)	133(19.3)	175 (25.4)	29 (4.2)	15 (2.2)	12 (1.7)	51(7.4)	0

- Multiple responses were possible
- Percents are in bracket

5.4 Associated factors affected parent-adolescent communication on SRH issues.

The observed associations in bivariate analysis were reassessed by multivariate analysis to identify adjusted association with the probability of parent -adolescent communication. As can be seen from the table, variables such as educational level of the adolescents, knowledge on selected SRH issues and perceived openness on importance of communication were associated with parent adolescent communication. After controlling for other variables educational level of the adolescents, knowledge on contraceptives and perceived openness on communication were significant.

Respect to students' educational level, grade10 adolescents had 1. 6 times more communicated on SRH issues with their parents when compared to grade 9 adolescents (AOR=1.55, 95%CI: 1.05, 2.30). And grade 11 adolescents had 1. 7 times more communicated on SRH issues with their parents when compared to grade 9 adolescents (AOR=1.67, 95%CI: 1.02, 2.74).

Adolescents who had knowledge on contraceptive methods were 2.5 times more communicated on SRH issues either of their parents than who had less knowledge (AOR = 2.50, 95% CI: 1.53, 4.08) Adolescents who agreed on importance of communication regarding SRH issues were 2.4 times more communicated with their parents than those who said it is not important (AOR= 2.39, 95% CI: 1.56, 3.65).

Table 5: Adolescents who communicated on at least two topics of SRH issues with their parents by different socio-demographic and other variables at Fagita Lokoma District , April 2012.

Variables	Parent-adolescent communication		COR(95% CI)	AOR(95% CI)
	Yes	No		
Educational status (Grade)				
9	162	114	1.00	1.00
10	110	132	1.71(1.20, 2.42) *	1.55(1.05,2.30) *
11	49	57	1.65(1.05, 2.60) *	1.67(1.02,2.74) *
12	27	37	1.95(1. 12,3.39) *	1.051.11,3.80) *
Knowledge on: Contraceptive, methods				
Yes	314(90.2)	241	3.79(2.48, 5.80) *	2.50(1.53,4.08) *
No	34(9.8)	99	1.00	1.00
Perceived openness : Yes	298	225	3.05(2.10, 4.43) *	2.39(1.56,3.65) *
No	50	115	1.00	1.00

- Significant P. value<0.05

5.5 Focus Group Discussion of the parents:

Thirty-two parents, (16 females and 16 males) were involved in 4 focus group discussions. Out of all participants16 (1/2) were from urban and the remaining from rural areas. All of the respondents were married and Orthodox Christians. Eight (1/2) of male participants were farmers. One third of female participants were illiterate. Age of participants was (32-54) years, and 24(3/4) of participants were Agew in ethnicity. The FGD were conducted separately for male and female parents.

5.5 .1 Knowledge of parents on selected sexual and reproductive health issues.

Contraceptive- twenty-eight of the participants said that "*contraception uses for preventing unintended pregnancy".*

HIV/AIDS**-**thirty of the participants mentioned as " *HIV/AIDS can be transmitted by sexual contact*".

Unwanted pregnancy -a participant said that "*unwanted pregnancy occurs when adolescents engaged in premarital sex and, this may even endanger their lives as the result of trying to abort* ". Similarly one female parent forwarded that "*adolescents wanted to identify or resemble what their peers or friends do, so she wants to have boy friend. Therefore, she may get pregnant if she did not protect herself* ".

Menstrual period- twenty-eight of the discussants link menstrual period with a fertile time (that means, she is ready to get pregnant if she has got sexual contact) and it comes every month. One female discussant explained that " it comes every month at the age of 15 year old and in female who has affluent family she may see even as early as 15year old or lower ".

Puberty- thirty of the participants explained that " *during puberty most adolescents did not accept order as they used to in early age*". One of the discussant said that "*this stage is very dangerous, they will not accept our advice and they will be in danger of acquiring transmissible disease like HIV/AIDS and exposed to unwanted pregnancy* ".

When the parents who participated in the FGD sessions were asked whether the adolescents should have access to reproductive health information or not, it is clear that 26 parents, both urban and rural, agreed that the provision of the information is very important to the adolescents. Typical responses obtained from the FGD included the following:

Twenty six of the parents said that it guarantees them for future life, they will know what is bad and good, protects them from disease(HIV/AIDS), they will be free of bad names and rumor both to their family and themselves too. One of the male parents forwarded his idea by saying " *I personally accept communication but before we communicate with them they have to know the importance of communication on SRH issues; otherwise they don't hear us rather said ("aye")a negative response*". Two of the female parent forwarded their idea by saying, for instance menses if it comes for the first time she will feel discomfort if no discussion before.

"We should tell them to stay away from sex from now because of the dangers and complication of unprotected sex" (FGD with urban fathers) .

However, six parents, during the FGD, opined that sexuality issues should not be communicated with adolescents as such would unnecessarily expose them to sex.

one male participant said that "*the adolescents will become more promiscuous if they have more information about it*".

One of the parents said that "*It is not good, it will make the adolescents more wayward and even say my parent was the one that taught me about how to use contraceptives*"(FGD with urban fathers).

"*It is not proper to teach them about contraceptive use because they are not ready to start procreating*"(FGD with rural fathers).

Communication between parents and adolescents was restricted to talking on general and non-sensitive issues like school, work etc. communication was more on biological issues but on more sensitive issues, such as pubertal changes in boys, unwanted pregnancy, sexual intercourse, condom, premarital sex and HIV/AIDS in adolescents were negligible.

One participant "*we don't speak on these issues (laugh) such as Sexual relations*, *nothing we talk*!" - FGD with rural mothers

Textual data throw light into the content of the conversation on menstruation:

"*We told about menses*. *Wash the cloth in hot water and dry in the sun so that there is no infection*". – FGD with urban mothers.

"*How to take the cloth, change the napkin for 2 times in a day. Take cotton cloth. Bleeding is there. This information was given*." - FGD with urban mothers.

Twenty six parents would like to communicate with their adolescents about sexual issues, but they do so superficially or not at all, the reasons for this reported by the parents were culture, embarrassment, ' shame, fear of encouraging them to engage in sexual activities, parents' insufficient knowledge, thinking it is still too early to communicate sexual matters with adolescents.

One male parent participant said, "*I don't discuss on sexual issues and menses, this creates me discomfort and even this is not culturally acceptable*", just we talked in general terms ("*dar darun bemenger kalhon besteker*")

6. Discussion

This study has attempted to assess communication on sexual and reproductive health issues among in school adolescents and selected parents at Fagita Lokoma Districts in Awi Zone, ANRS, Northwest Ethiopia.

Parent-adolescent communication on two or more sexual and reproductive health topics was 50.6%. This finding is higher than other studies conducted in Ethiopia, Bullenworeda benishangul gumuz region (28.9%) and Zeway (20%) (3, 32).The possible explanation for this difference may be due to time variation since the study was conducted 4 years back and promotion activities implemented by females clubs in schools and youth friendly programs in some health institutions of the study area. Moreover, this difference might be explained by the fact that this study was carried out in the time when health extension program were employed and strengthen which is a reliable means of reaching people at home. Currently, the health extension workers make frequent visits to all households of their catchment areas to teach, persuade and motivate to adopt the new health actions.

But this finding is lower than similar studies conducted In Nigeria 75.2% indicated that they had communicated sexual issues with their adolescents*;* in Mexico as many as 83.1% adolescents having communication with parents about sexual and RH issues and in U.S 75% of the adolescent had received SRH communication(19 , 22, 26). The possible reason for the difference could be developmental and socio cultural variation**.** When the country civilized the access of education and infrastructure like youth centers are increased. In USA from grade seven and above provided information about the value of abstinence, on how to prevent pregnancies that include birth control pills, condoms, the spread of STDs and who do decide to have sex, for students as part of the curriculum.

Although, 26 parents participated in FGD approved the importance of communicating SRH issue with their adolescent. communication between parents and adolescents was restricted to talking on general and non-sensitive issues like school, work etc. similar study in India Communication on more sensitive issues, such as pubertal changes in boys, unwanted touch, sexual intercourse, conception, boy girl friendship and HIV/AIDS, in adolescent's perspective, was negligible by parents (12). Similarly in California many parents would like to communicate with their adolescents about sexual issues, but they do so superficially or not at all, because they lack necessary communication skills, knowledge, or comfort (15)

In the present study 6 parents in FGD were unwilling or unable to communicate this important and sensitive part of life with their adolescents considered it as a negative and a taboo rather than as a natural part of being human. This finding is consistent with a study conducted in china and California, USA(15,22).

In this study parents in FGD stated that present- adolescent communication was more on biological issues and communication on relationships and sexual intercourse focused more on negative aspects such as STD and unintended pregnancy and tend to focus more on the negative consequences of sex than the positive consequences of using protection if one is sexually active. This finding is also consistent with the study conducted in India and in California (12 , 15). Those the FGD conducted in this study, which may indicate that there is a gap in communicating the positive aspect of adolescent sexuality related issues.

In this study results showed that 38.5% the respondents felt it easy to communicate sexual matters with their mothers while 79.8% felt it was difficult to communicate sexual matters with their fathers. Similarly, studies on secondary school students in Zambia 30% felt it was easy to communicate sexual matters with their mothers and 77% felt it was difficult to communicate sexual matters with their fathers; in India mothers emerge as the better listeners and more understanding of their point of view for both adolescent boys and girls (>90%) as compared to the father (65 -80%). Study conducted in USA showed that 77 percent of their mothers engaged in some level of sexuality communication with them compared to only 37 percent of their fathers (5 , 15 **,** 17**)** .

In this present study on FGD parents stated that adolescents were more comfortable discussing SRH issues with mothers than fathers. This findings is consistent with the studies done elsewhere (13**,** 19, 20)

This study revealed that students' educational status , were significantly associated with parent -adolescent communication , grade 10 students had 1. 6 times more communicated on SRH issues with their parents when compared to grade 9 students (AOR=1.55, 95%CI: 1.05, 2.30). Grade 11 students had 1. 7 times more communicated on SRH issues with their parents when compared to grade 9 students (AOR=1.67, 95%CI: 1.02, 2.74). This study is consistent with the study conducted at Bullenworeda Benishangul gumuz(3). This could be due to the fact that as educational level increases, ability to retain different information among adolescents increase so they may acquire additional knowledge about SRH issues which intern leads to favorable attitude to parent- adolescent communication on SRH issues.

Adolescents who have knowledge on contraceptive were 2.5 times more communicated than who had less knowledge(AOR = 2.50, 95% CI: 1.53, 4.08) . The possible explanation may be as students become exposed to information regarding contraceptive, their knowledge become improved. As a result, they could have favorable attitude towards communication on SRH issues with their parents.

Adolescents who agreed on importance of communication regarding SRH issues were 2.4 times more communicated than those, who said no importance (AOR= 2.39, 95% CI: 1.56, 3.65). Therefore, those adolescents who had attitudes on the importance of communication on SRH issues with parents , were more likely to communicate.

Maternal educational status were not statistically significant in communicating on SRH issues(AOR= 0.37, 95% CI: 0.14, 1.02) ,however the study conducted at Bullenworeda Benishangul gumuz maternal educational status were statistically significant in discussing. Similar to this current finding study done in *Nigeria using multistage sampling technique,* the result revealed that there was no significant relationship between maternal educational attainment and sexual communication (3*,* 12).

The possible justification for this discrepancy from the study done at Bullenworeda Benishangul gumuz might be socio-cultural, sample size difference. It was discovered that even mothers whose educational attainment was just secondary education averagely communicated sexual issues more than those with tertiary educational qualifications.

Five hundred ninety eight (86.9%) of the adolescents reported that they had communicated on STI/HIV/AIDS. Which is high compare to the study done in Bullenworeda benishangul gumuz region high school students (78.6%)but consistent with study done in Tehran (87%) (3 , 27). Time and geographical variations could be the possible reason for the difference**.**

Regarding the influence of culture in this study 28.3% of the students reported that it is culturally unacceptable to communicate on sexual intercourse in adolescents with parents. But the current result is low as compared to study done in selective region of Ethiopia to assess young people's HIV/AIDS and RH needs in utilization of services that revealed 71.7% of participants agreed that the socio-cultural norm were the major barriers to adolescent-parent communication(32) Time variation could be the possible reason for the difference**.**

Also parents in FGD indicated various reasons why they did not communicate with their adolescents about reproductive health issues. Twenty four of the parents worried about their culture which was consistent with study conducted in selective region of Ethiopia(32)

A proportion (59%) of adolescents claimed difficulty of initiating due to lack of knowledge. Similarly study done on similar issue in Uganda (68.4%) adolescents lacked knowledge in communicating with their parents (25). It is also in harmony with Studies conducted in China, Kenya and Sweden that indicated that due to lack of knowledge to communicate physical, psychological and body changes during adolescents with parents (21, 30, 31)

7. Strength and limitation of the study

7.1 Strength of the study

The sampling technique employed, the achievement of high response rate, the use of appropriate methods to minimize bias and combining quantitative and qualitative data could be also mentioned as the strength of the study. Privacy of the respondents were also kept and pretest were conducted.

7.2 limitation of the study

It is not included under -served adolescents since the study place was only in school adolescents.

Communication on SRH is based on self reported information, which is subjected to reporting errors and biases. Since the study touches sensitive and intimate issues the possibility of underestimation cannot be ruled out. Some sort of desirability bias may not be eliminated even the survey was anonymous. Finally, this study is based on cross-sectional data, which implies that the direction of causal relationships cannot always be determined.

8. Conclusion and Recommendations

8. 1 Conclusion

There were good attitude toward the importance of communication on SRH in both the study population (adolescents and parents). However, communications on sexual and reproductive health issues were more with their friends/peers than parents. This could have two important impact if peers are not equipped with appropriate information on SRH related may influence each other in negative way where as if they are equipped with appropriate information on SRH related they can pass easily an influence each other positively.

This finding concludes that there was low parent-adolescent communication on SRH issues. The focus group discussion revealed that the content of parent-adolescents conversation focus more on the negative outcomes of sexual intercourse and sexuality and poor on what adolescents should know and understand how they are growing and developing this will make adolescent unlikely to turn to their parents to discuss with them comfortably. Finally, the study also concluded that adolescents and parents have low communication on sexual and RH related issues still continues to be lack of knowledge, cultural taboo and shame by both adolescents and their parents.

9.2 Recommendation:

Based on the findings, therefore, the following recommendations are suggested.

1. MOH, ANRSHB and NGOs

- Design and implement a strategy to increase knowledge and attitude of adolescents and parents about SRH issues.
- organize adult training programmes on sex education.
- encouraged to be actively involved in sensitizing parents on the need to be involved in sex education of their adolescents using Mass media.
- Improved parent-adolescent communication through intervention programs which focus on knowledge and skills.

2. ANRS HB.

- Comprehensive family life education (FLE) would be initiated for the adolescents and parents in school, home, churches, mosques, and health facilities.
- There is a need to equip parents with appropriate IEC material and communication skill on sexuality and RH related issues.

3 Fagita Lokoma health office and health facilities

- Sensitize the community to encourage open discussion among family members in general and between parents and adolescents in particular.
- Make IEC materials like pamphlets and posters available in all libraries of schools, Health institutions and other accessible areas to raise adolescents' knowledge on SRH issues
- Establish youth friendly programs in health institutions and strengthen the already available centers
- Arrange school health information dissemination programs

4 Fagita Lokoma Education Office and preparatory schools

- Introduced effective sex education to students at an early age.
- Organize RH clubs in schools and include SRH issues as one component of mini media programs.
- Strengthen IEC in schools on SRH with special emphasis to different adolescent health problems collaboration with the health sector

5. Further studies should be conducted to examine what triggers, quality and timing of parents–adolescents communication on sexuality and reproductive health related issues and the effect of communication on safe sexual behaviors.

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10. Annexes:

Annex 2: Questionnaires

English Version Data collection tools

1.Self administered structured questionnaire English version about assessment of Parent-Adolescent communication on sexual and reproductive health issues for adolescents and FGD for parents At Fagita Lokoma districts In Awl Zone, Northwest Ethiopia, 2012.

2. **Informed consent**

2.1 Introduction

My name is _____I came from University of Gondar, College of medicine and Health sciences, institute of public health. I am here to gather information about parent-adolescent communication on sexual and reproductive health issues. You will stay with us for 20-25 minutes. The purpose of the study is to improve health of adolescent, understanding of existing health problems and related behaviors by generating information about communication between adolescents and parents on adolescent sexual and RH issues and factors affecting communication between them to improve future reproductive health interventions.

You are selected to participate in this study. The selection of the individual was done randomly using a type of lottery method. I am assure you all your response will be completely confidential and none of your response will be reported to anybody separately. No need to write your name on the survey paper. It is your right to participate or refuse the study but I kindly request your kind and willingness to participate in the survey in order to meet its goal and benefit for future generation. So, are you willing to stay with us for few minutes to answer the questions?

1. Yes 2. No

If yes, go to the next page and give your responses for the questions provided.

Thank you for your participation !!

Instruction

Please choose and circle the answer that is most appropriate and provide words where applicable.

Part-I: Questions on Socio-Demographic Characteristics of respondents.

Ser. No.	Questions	Responses	Skip to/code
101	How old are you? (Age in years)	---------- years	
102	What is your religion?	1. Orthodox 2. Protestant 3. Muslim 4. Others(specify)----------	
103	With whom are you living currently?	1. Lives with mother and father 2. With mother only 3. With father only 99. Others	
104	Where is your residence?	1. Urban 2. Rural	
105	In which grade are you?	1. Grade 9 2. Grade 10 3. Grade 11 4. Grade 12	

106	What Ethnic group do you belong to?	1. Amhara 2. Tigrie 3. Oromo 4. Agew 5. Other specify ----------	
107	Your family size	……in number	
108	Sex	1. male 2.female	
109	Mother's educational status	1. Illiterate 2. Read and write only 3. Primary school 4. Secondary school 5. Diploma 6. Degree 7. No mother	
110	Father's educational status	1. Illiterate 2. Read and write only 3. Primary school 4. Secondary school 5. Diploma 6. Degree 7. No father 99. Others	
111	Occupation of the mother	1. House wife 2. Employed (private) 3. Employed (Governmental) 4. Small scale merchant 5. Farmers 6. No mother 99. Others	
112	Occupation of the father	1. Employed (private) 2. Employed (Governmental) 3. Small scale merchant 4. Farmers 5. No father 99. Others	
113	Marital status of the mother and Father?	1. Together 2. Separated 3. Divorced 4. Widowed	

Part-II: Knowledge on major selected Reproductive health.

Ser. No.	Questions	Responses and codes	Skip to
201	Do you know contraceptive method?	1.Yes 2. No	If your answer is 'No' skip to question no/ 203
202	If yes which one do you know? (circle all answerer you think)	1.pill 2.Depo proverb 3.Nor plant 4 .IUD 5.condom 6.Abstince 7. Using safe period.	
203	Do you know STD /HIV/AIDS?	1.Yes 2. No	If your answer is 'No' skip to question no/ 205
204	If yes which one do you know(circle all answer you think)	1.chancroid 2.syphilis 3.gonorrea 4.LGV 5.HIV/AIDS 6.herpse simplex 7.others-----	
205	Do you know when menstrual cycle start?	1.Yes 2. No	
206	If yes at what age it starts?	…….years	

Part-III: Parent -adolescent communication on sexual and reproductive health issues

Ser. No.	Questions	Responses and codes	Skip to
301	Is it important to discuss (communicate) sexual issues with parents?	1. Yes 2. No	
302	Which parent do you prefer to discuss on sexual and RH issues?	1. Mother 2. Father	
303	Have you ever discussed on contraception?	1. Yes 2. No	If your answer is 'No' skip to question no/ 305
304	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify…….	
305	If you do not discuss on question no/ 303 with parents. What do think the reasons are?)	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Parents are not good listener 5. Lack of communication skill 6. Difficult and embarrassing 88. Do not know 99. Others	
306	How frequent have you discussed about contraception?	1. Very often 2. Often 3. Sometimes	
307	Have you ever discussed on STD/HIV?	1. Yes 2. No	If your answer is 'No' skip to question no/ 309

308	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify…….	
319	If you do not discuss on question no/ 307 HIV/STD with parents. What are the reasons?	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not good listener 6. Difficult and embarrassing 88. Do not know 99. Others	
310	How frequent have you discussed about HIV/STD?	1. Very often 2. Often 3. Sometimes	
311	Have you ever discussed on sexual intercourse?	1. Yes 2. No	If your answer is 'No' skip to question no/ 313
312	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify…….	
313	If you do not discuss on question no/ 311 with parents. What are the reasons?	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 88. Do not know 99. Others	

314	How frequent have you discussed about sexual intercourse?	1. Very often 2. Often 3. Sometimes	
315	Have you ever discussed about unwanted pregnancy?	1. Yes 2. No	If your answer is 'No' skip to question no/ 317
316	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify……	
317	If you do not discuss on question no/ 315with your parents. What are the reasons?	1. Culturally unacceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 88. Don't know 99. Others	
318	How frequent have you discussed about un Wanted pregnancy?	1. Very often 2. Often 3. Sometimes	
319	Have you ever discussed on not having sex until marriage?	1. Yes 2. No	If your answer is 'No' skip to question no/ 321
320	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify……	

321	If you don't discuss on question no/ 319 (not having sex until marriage) with parents. What are the reasons? (Circle all answer you think)	1. Culturally un acceptable 2. Shame 3. Lack of knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 88. Don't know 99. Others	
322	How frequent you have discussed about on not having sex until marriage?	1. Very often 2. Often 3. Sometimes	
323	Have you ever discussed on condom?	1. Yes 2. No	If your answer is 'No' skip to question no/ 325
324	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify…….	
325	If you don't discuss on condom With parents, what are the reasons? (circle all answer you think)	1. Culturally un acceptable 2. Shame 3. Lack of Knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 88. Don't Know 99. Others	
326	How frequent you have discussed on condom?	1. Very often 2. Often 3. Sometimes	
327	Have you ever discussed on physical and psychological changes on puberty?	1. Yes 2. No	If your answer is 'No' skip to question no/ 329

328	With whom have you discussed? (circle all answers you think)	1. Father 2. Mother 3. Peer 4. Sisters 3. Brothers 99. Others specify…….	
329	If you don't discuss on question no/327 With parents. What are the reasons?(circle all answer you think)	1. Culturally un acceptable 2. Shame 3. Lack of Knowledge 4. Lack of communication skill 5. Parents are not a good listener 6. Difficult and embarrassing 88. Don't Know 99. Others	
330	How frequent you have discussed on physical and psychological changes on puberty?	1. Very often 2. Often 3. Sometimes	
331	If you have ever discussed at least one of the above issues with your parents, at what age have you started discussing it?	……age in years	
332	At what age do you think discussion on sexual and reproductive health should be started?	…….age in years	
333	Is your father open to discuss?	1.Yes 2. No	
334	Is your mother open to discuss?	1.Yes 2. No	

Thank you !!

Focus group discussion

Discussion to parents on extent of communication parents with their adolescents on SRH issues and factors affecting communication.

The guideline will be as follow:

1. Greeting
2. Ask the willingness of the parents for participating in the discussion.
3. Explain the objective of the study and focus group discussion.
4. Telling the participant that confidentiality will be maintained
5. Telling participant we will use tape recorder in order to capture their opinion fully and ask the willingness of the parents .
6. Systematic avoidance of dominate participant.
7. Topics to be discussed

7.1. What do you think, the knowledge of parents on reproductive health? (Contraception, STD/HIV/AIDS, and Puberty)

7.2. What is the feeling of parents on premarital sex and unwanted pregnancy in adolescents?

7.3 What is your suggestion for sex education first do they agree?

If you agree why?

If you agree not why not?

Where do you prefer sex education to be given? (School, friends, home, church)

7.4. Is it important to discuss sexual matters with adolescents?

If yes why?

If no why not?

7.5. In which age do you suggest communicating/discussing on sexual matters starting?

7.6. Are you comfortable, skillful when discussed with your adolescents on sexual matters ?

If you are not communicated what are the reasons (barriers) for not communicating/discussing on sexual matters?

Annex-3 Amharic Questionnaire

ሀ/ መግቢያ

በጐንደር ዩኒቨርስቲ፣ህክምና ጤና ሳይንስ ኮሌጅ፣የህብረተሰብ ጤና አጠባበቅ ትምህርት ቤት የወላጆች አቅመአዳም/ህይዋን ከደረሱ ልጆቻቸዉ ጋር በስነ ተዋልዶ ዙሪያ ግልጽ ውይይትን በተመለከተ በወላጆች እና በተማሪዎች ላይ ጥናት ለማካሄድ የተዘጋጀ መጠይቅ።

ጤና ይስጥልኝ ስሜ _____ እባላለሁ። እዚህ የመጣሁት ከጐንደር ዩኒቨርሲቲ የህብረተሰብ ጤና አጠባበቅ ትምህርት ቤት ተማሪ የሆኑትን አቶ ተሰጋ መንግስቱን ወክየ ነው። የመጣሁበት ዋና አላማ የወላጆች አቅመአዳም/ህይዋን ከደረሱ ልጆቻቸዉ ጋር በስነ ጾታ ዙሪያ ግልጽ ውይይትን በተመለከተ ለማወቅ የተዘጋጀ መረጃ ለመሰብሰብ ነው። ከሃያ እስከ ሃያ አምስት ደቂቃ ያህል አብረን እንቆያለን።

ለ/ የጥናቱ ዋና አላማ

የወላጆች አቅመአዳም/ህይዋን ከደረሱ ልጆቻቸዉ ጋር በስነ ተዋልዶ ዙሪያ ግልጽ ውይይትን በተመለከተ ለማወቅና ከዚህ ጋር ተያያዥነት ያላቸውን ዋና ዋና ምክንያቶች ለመለየት ነው።ይህም በወጣቶች ላይ የሚደርሱ ከስነ ተዋልዶ ጋር የተያያዙ ዘርፈ ብዙ የጤና ችግሮችን በመረዳት የወጣቶችን የጤና ኘሮግራም ለማሻሻል ስለሚጠቅም ነው። የሚሰጡት መልስና የጥናቱ ውጤት በሚስጢራዊነት ይጠበቃል። በዚህ ጥናት የሚሰበሰበው እርስዎን የሚመለከት መረጃ ከዋናው ተመራማሪ በስተቀር ለማንም አይገለፅም። ስምወትን በጥናት ወረቀቱ ላይ መፍ አያስፈልግም። በጥናቱ ያለመሳተፍ መብትዎ የተጠበቀ ነው። ነገር ግን ጥናቱ ግቡን እንዲመታና ለእርስወና ለመጭው ትውልድ ጠቀሜታ ስለሚኖረው በጥናቱ እንዲሳተፉ በትህትና እጠይቃለሁ። ለዚህ ጥናት የተመረጡት በእጣ /ከሌሎች በማወዳደር/ ነው።

ስለዚህ ለቀረቡት ጥያቄወች መልስ ለመስጠትና ከእኛ ጋር ለተወሰኑ ደቂቃወች አብሮ ለመቆየት ፈቃደኛ ነዎት?

አዎ 2. **አደለሁም**

አዎ ካሉ በሚቀጥለው ገፅ ላሉት ጥያቄዎች መረጃ እንዲሠጡኝ በትህትና እጠይቃለሁ።

አመሰግናለሁ።

መመሪያ፡ ቀጥሎ ለቀረቡት ጥያቄወች በጣም ትክክል ነው የሚሉትን ከቀረቡት አማራጮች በመምረጥ ቁጥሩን ይክበቡ፡፡

ክፍል 1፡- በማህበራዊና ስነ-ህዝብ ጉዳዮች ላይ የተዘጋጀ መጠይቅ::

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ወደ.....ይለፉ
101	እድሜ	.....አመት	
102	ሃይማኖ	ኦርቶዶክስ ፕሮቴስታንት ሙስሊም 99.ሌላ ካለ ይገለጽ--------	
103	የምትኖረው/ሪው ከማን ጋር ነው?	1. ከእናትና አባት/ሽ ጋር 2. ከእናት ጋር ብቻ 3. ከአባት ጋር ብቻ 99.ሌላ ካለ ይገለጽ--------	
104	የሚኖሩበት ቦታ	1. ከተማ 2. ገጠር	
105	የትምህርት ደረጃ	1. 9ኛ ክፍል 2. 10ኛ ክፍል 3. 11ኛ ክፍል 4. 12ኛ ክፍል	
106	ብሔረሰብ	1. አማራ 2. ትግሬ 3. አገው 4. ሌላ ከሆነ ይጠቀስ ----------	
107	የቤተሰብ ብዛት	በቁጥር--------	
108	የወላጆች የገቢ መጠን በወር	1. ---------- 88. አላውቅም	

109	የእናት የትምህርት ደረጃ	8. ያልተማረች 9. ማንበብና መጻፍ 10. አንደኛ ደረጃ 11. ሁለተኛ ደረጃ 12. ዲፕሎማ 13. ዲግሪ 14. እናት በህይወት የለችም	
110	የአባት የትምህርት ደረጃ	1 ያልተማረ 2 ማንበብና መጻፍ 3 አንደኛ ደረጃ 4 ሁለተኛ ደረጃ 5 ዲፕሎማ 6 ዲግሪ 7 አባት በህይወት የለም	
111	የእናት የስራ ሁኔታ	7. የቤት እመቤት 8. በግል ተቀጣሪ 9. በመንግስት ተቀጣሪ 10. ነጋዴ 11. ገበሬ 12. እናት በህይወት የለችም 99.ሌላ ካለ ይገለፅ_____	
112	የአባት የስራ ሁኔታ	1.በግል ተቀጣሪ 2. በመንግስት ተቀጣሪ 3. ነጋዴ 4. ገበሬ 5. እናት በህይወት የለችም 99.ሌላ ካለ ይገለፅ_____	
113	የእናት እና የአባት ሁኔታ?	1. በአንድላይ ናቸዉ 2. ተለያይተዋል(በአንድላይ አይደሉም) 3. ተፋተዋል 4. አንደኛናቸዉ በህይወት የሉም	

ክፍል 2፡- በተመረጡ የስነተዋልዶ ጤና ላይ የእውቀት ጥያቄዎች፡

ተ.ቁ	መጠይቆች	አማራጭ መልሶች	ወደ----------ይለፉ
201	የወሊድ መቆጣጠሪያዎችን ታውቃለህ/ሽ?	1 አዎ 2 አይ	መልስህ/ሽ አይ ከሆነ ወደ ጥያቄ 203ቁጥር እለፍ/ፊ
202	አዎ ካልክህ/ሽ የምታውቃቸዉን/ቂያቸዉን? አክብብ/ቢ	1. የወሊድ መቆጣጠሪያ ኪኒን 2. የወሊድ መቆጣጠሪያ መርፌ 3. ክንድ ውስጥ የሚቀበር 4. መህፀን ውስጥ የሚቀመጥ 5. ኮንዶም 6. መታቀብ 7. ካላንደር በመጠቀም	
203	በግብረስጋ ግንኙነት ስለሚመጡ በሽታዎች ታውቃለህ/ሽ?	3. አዎ 4. አይ	መልስህ/ሽ አይ ከሆነ ወደ ጥያቄ 205ቁጥር እለፍ/ፊ
204	አዎ ካልክ/ሽ የትኛውን ታውቃለህ/ሽ የምታውቂያቸውን መልሶች Aክብቢ	1. ቻንክሮይድ 2. ጨብጥ 3. ቂጥኝ 4. ባምቡሌ 5. ኤች.አይ.ቪ/ኤድስ 6. ኸርፐስ ሲምፕሌክስ 13. ሌላ ይገለጽ_____	
205	የወር አበባ የሚጀምርበትን እድሜ ታውቃለህ/ሽ	1.አዎ 2. አይ	
206	አዎ ካልክ/ሽ የመጀመሪያ የወር አበባ በስንት አመት ይጀምራል?	----------በአመት ይገለፅ	

ክፍል 3፡- በወላጆችና በልጆች መካከል በስነተዋልዶ ጤና እና በግብረስጋ ግንኙነት ላይ የሚደረጉ ውይይቶች፡

ተ.ቁ	ጥያቄ	አማራጭ መልሶች	ወደ----------እለፊ
301	በወላጆችና በልጆች መካከል በግብረስጋ ግንኙነት ላይ ያሉ ሁኔታዎች ላይ መወያየት አስፈላጊ ይመስልሀል/ሻል?	1. አዎ 2. የለም	
302	ከየትኛው ወላጅ ጋር መወያየቱ ይሻላል ብለህ/ሽ ታስባለህ/ሽ?	1. ከእናት ጋር 2. ከአባት ጋር	
303	ስለ ወሊድ መቆጣጠሪያ ተወያይተውህ/ሽ ታውቃህ/ሽ?	1.አዎ 2.የለም	መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 305ቁጥር እለፍ/ፊ
304	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ግዜ ከማን ጋር ታደርጋለህ/ሽ?	1. ከአባት ጋር 2. ከእናት ጋር 3. ከጓደኞች ጋር 4. ከእህት ጋር 5. ከወንድም ጋር 99.ሌላ ካለ ይገለፅ.....	
305	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ.....	
306	ምን ያህል ጊዜ ስለ ወሊድ መቆጣጣሪያ ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	

307	ስለ ኤችአይቪ/ኤድስ ከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ?	1 አዎ 2 አይ	መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 309ቁጥር እለፍ/ፊ
308	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ?	1. ከአባት ጋር 2. ከእናት ጋር 3. ከጓደኞች ጋር 4. ከእህት ጋር 5. ከወንድም ጋር 99.ሌላ ካለ ይገለፅ.....	
309	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ.....	
310	ምን ያህል ጊዜ ስለ ኤችአይቪ/ኤድስ ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	

311	ስለ ግብረስጋ ግንኙነትከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ?	1 አዎ 2 አይ	መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 313ቁጥር እለፍ/ፊ
312	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር 3. ከጓደኞች ጋር 4. ከእህት ጋር 5. ከወንድም ጋር 99.ሌላ ካለ ይገለፅ.....	
313	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ.....	
314	ምን ያህል ጊዜ ስለግብረስጋ ግንኙነት ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	
315	ስለ አልተፈለገ እርግዝና ከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ?	1 አዎ 2 አይ	መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 317ቁጥር እለፍ/ፊ
316	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር 3. ከጓደኞች ጋር 4. ከእህት ጋር 5. ከወንድም ጋር 99.ሌላ ካለ ይገለፅ.....	

317	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ.....	
318	ምን ያህል ጊዜ ስለ አልተፈለገ እርግዝና ከወላጆችህ/ሽ ጋር ተወያይተሻል/ህል?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	
319	ከጋብቻ በፊት የግብረስጋ ግንኙነት ስለአለማድረግ ከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ?	1 አዎ 2 አይ	መልስህ/ሽ አዎ ከሆነ ወደ ጥያቄ 320ቁጥር እለፍ/ፊ
320	አዎ ካልክ/ሽ ውይይቱን በአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1. ከአባት ጋር 2. ከእናት ጋር 3. ከጓደኞች ጋር 4. ከእህት ጋር 5. ከወንድም ጋር 99.ሌላ ካለ ይገለፅ.....	
321	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ.....	
322	ስለ ኮንዶም ከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	

323	አዎ ካልክ/ሽ ውይይቱን በአአብዛኛው ጊዜ ከማን ጋር ታደርጋለህ/ሽ	1 አዎ 2 አይ	መልስህ/ሽ1 አዎ ከሆነ ወደ ጥያቄ 325ቁጥር እለፍ/ፊ
324	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1. ከአባት ጋር 2. ከእናት ጋር 3. ከጓደኞች ጋር 4. ከእህት ጋር 5. ከወንድም ጋር 99.ሌላ ካለ ይገለፅ.....	
325	ምን ያህል ግዜ ስለ ኮንዶም ከወላጆችህ/ሽጋር ተወያይተሻል/ሀል?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3. የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ.....	
326	ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተህሽ ታውቃለህ/ሽ?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	
327	የማትወያዩ ከሆነ ምክንያቱ ምንድነው ብለህ/ሽ ታስቢያለሽ/ህ?	1 አዎ 2 አይ	መልስህ/ሽ የለም ከሆነ ወደ ጥያቄ 329ቁጥር እለፍ/ፊ
329	ምን ያህል ግዜ ጉርምስና በሚጀምርበት ወቅት ስለሚከሰቱ የሰውነትና የስነልቦና ለውጦች ከወላጆችህ/ሽ ጋር ተወያይተሻል/ሀል?	1. በባህል ተቀባይነት የለውም 2. እፍረት 3.የእውቀት ማነስ 4. ወላጆች ጥሩ አዳማጮች አይደሉም 5. ወላጆች ከልጆች ጋር የመግባባት ችሎታ የላቸውም 6. እርእሶቹ ከባድና የሚያበሳጩ ናቸው 88.አላውቅም 99.ሌላ ካለ ይገለፅ	

330	አንተ/አንቺ ከወላጆችህ/ሽ ጋር በስነ ተዋልዶ ጤና እና በግብረስጋ ግንኙነት ዙሪያ ቢያንስ ሁልትና ከዚያ በላይ ተወያያተሃል/ሻል? ስትጀምሪ/ር ስንት አመትህ/ሽ ነበር?	1 በጣም በብዛት 2 በብዛት 3 አንዳንዴ	
331	በስንት አመት ይጀመራል ብለሽ/ህ ታሲባልሽ/ህ ?	.....አመት	
332	አባትህ/ሽህ/ሽ በስነተዋልዶ ጤና እና በግብረስጋግንኙነት ዉይይት ለማድረግ ግልፅ ነቸዉ?	.....አመት	
333	እናትህ/ሽ በስነተዋልዶ ጤና እና በግብረስጋ ግንኙነትዉ ይይት ለማድረግ ግልፅ ነቸዉ?	1 አዎ 2 አይ	
334	አባትህ/ሽ በስነተዋልዶ ጤና እና በግብረስጋ ግንኙነትዉ ይይት ለማድረግ ግልፅ ነቸዉ?	1 አዎ 2 አይ	

አመሰግናለሁ::

በስነተዋልዶ ጤናና በፆታዊ ጉዳዮች ወላጆች ከወጣት ልጆቻቸዉ ጋር ለሚያደችጉት (FGD) መመሪያ፡

የዉይይቱ አካሄድ እንደሚከተለዉ ይሆናል፡፡

1. **ሰላምታ ማቅረብ**
2. **የተወያዮችን ፈቃደኝነት መጠየቅ**
3. **የጥናቱን ዋና አላማ ለተወያዮች በግልፅ ማብራራት**
4. **ለትወየዮች የዚህ ዉይይት ሃሳብ ለማንም ተላልፎ እንደማይሰጥ እና ሚስጢሩ የሚጠበቅ መሆኑን ማብራራት፡፡**
5. **የተወያዮችን ሀሳብ ሙሉበሙሉ ለመያዝ ይረዳ ዘንድ ቴፕ ሪከርደር መጠቀም እንድንችል ፍቃደኛ መሆናቸዉን መጠየቅ**
6. **ዉይይቱ በተሳካ ሁኔታ እንዲካሄድ የተወሰኑ ሰወች ዉይይቱን እንዳይቆጣጠሩት መከታተል**

7.የመወያያ ነጥቦች፡-

7.1. ወላጆች በስነተዋልዶ ያላችሁ እዉቀት ምን ይመስላል?

7.2. ወጣቶች በቅድመጋብቻ ለሚያደርጉት የግብረስጋ ግንኙንትና ያልተፈለገ እርገዝግእና ያላችሁ አመለካከት ምን ይመስላል?

7.3. በፆታዊ ጉዳይ እና ፆታዊ ገንኙነት ለወጣቶች ት/ት ቢሰጥ ጥሩ ነዉ ብላችሁ ታምናላችሁ?

-ከተስማማችሁ መክንያታችሁ ምንድን ንዉ?

-ካልተስማማችሁ መክንያታችሁ ምንድን ንዉ?

-ከተስማማችሁ ት/ቱ የት ቢሰጥ ጥሩ ነዉ? (ት/ት ቤት፣ጉደኛ፣ቤት፣ቤተ ክርስቲያን)

7.4. ከወጣቶች በስነተዋልዶ ጤናና በግብረስጋ ግንኙንት ዙሪያ መወያያት አስፈላጊ ነዉ ብላችሁ ታምናላእሁ?

-አስፈላጊ ነዉ ካላችሁ ለምን ?

-አስፈላጊ አይደለም ካላችሁ ለምን?

7.5.ከወጣቶች በስነተዋልዶ ጤናና በግብረስጋ ግንኙንት ዙሪያ መወያያት አስፈላጊ ነዉ ካላችሁ በየትኛዉ እድሜ ክልል መጀመር አለበት ትላላችሁ?

7.6. ወላጆች ከወጣት ልጆቻቸሁ ጋር በስነተዋልዶ ጤናና በግብረስጋ ግንኙንት ዙሪያ ዉይይት ሰታደርጉ(ያለመሸማቀቅ ደስተኛ ሆናችሁ ትወያያላችሁ)?

አንወያይም ካላችሁ ለምን?

Annex- 4: Information Sheet and Consent Form

Title of the Research Project

Assessment Of Parent-Adolescent Communication On Sexual And Reproductive Health Matters At Fagita Lokoma Districts In Awl Zone N/west Ethiopia 2012

Name of Principal Investigator: Tesega Mengistu

Name of the Organization: institute of Public Health, College of Medicine and Health Sciences, University of Gondar.

Name of the Sponsor: University of Gondar

Introduction

This information sheet and consent form is prepared with the aim of explaining the research project that you are asked to join by the group of research investigators. The main aim of the research project is to assess communication between adolescents and parents on adolescent sexual and RH issues and factors affecting communication between them at Fagita Lokoma districts. The research group includes trained diploma nurses, one supervisor from the town health office, and two advisors from University of Gondar.

Purpose of the Research Project

SRH issues in adolescents is a major public health problem in our country. communication between adolescents and parents on adolescent sexual and RH issues and factors affecting communication between them have not been assessed in the area. The results of this study will be used as a basis, especially in the study area, to design appropriate intervention programs to address the problem.

Procedure: to assess this project I invite you to take part in my project. If you are willing to participate in this project, you need to understand and sign the agreement form. Then you will be asked to give your responses by the data collectors. For participants who are not capable of giving responses to the questions either their illness or their being unwilling to participate, they will be exempted.

For this questionnaire based study, participants are all those students registered and attending in day time program of the school. All the responses given by the participants and results obtained will be kept confidential using coding system whereby no one will have access to your responses.

Risk and discomfort

By participating in this research project, you may fill that it has some discomfort especially on wasting your time(about 20 minutes) but this will not be too much as compared with its benefit it contributes to prevention of SRH problems in the future. No risk in participating in this study project.

Benefits:

If you participate in this research, you may not get direct benefit but your participation is likely to help us in identifying communication between adolescents and parents on adolescent sexual and RH issues and factors affecting communication between them and will have the benefit of effective prventing strategies to prevent SRH problems.

Incentives:

You will not be provided any incentive to take part in this research.

Confidentiality:

The information that we collect from this research project will be kept confidential. Information about you that will be collected from the study will be stored in a file, which will not have your name on it, but a code number will be assigned to it. Which number belongs which name will be kept under lock and key, and it will not be revealed to anyone except the principal investigator.

Right to refuse:

You have full right to refuse from participating this research (you can choose not to respond some or all questions) if you do not wish to participate; and this will not affect your education.

Whom to contact:

This research project will be received and approved by Ethical Committee and institute of Public Health of University of Gondar.

If you have any question, contact any of the following individuals and you may ask at any time you want:

1. Tesega Mengistu:- Principal investigator

   Tel: O9-18-71-36-33

2. Dr. Berihun Megabiw:- Advisor

   Tel: O9-18-04-60-01

3. Mr. Atnkut Alamirew :- Advisor

   Tel: O9-11-31-35-78

   Institute of Public Health, University of Gondar

Annex 5

የመረጃና የስምምነት ውል ቅፅ

የምርምሩ/ጥናቱ ርዕስ

በአማራ ብሔራዊ ክልላዊ ፣መንግስት በአዊ ዞን መስተዳድር፣ በፋግታ ሎኮማ ወረዳ የወላጆች አቅመ አዳም/ህይዋን ከደረሱ ልጆቻቸዉ ጋር በስነ ተዋልዶ ዙሪያ ግልጽ ውይይትን በተመ ለከተ በወላጆች እና በተማሪዎች ላይ ጥናት ማካሄድ::

የዋና ተመራማሪው ስም ፡ ተሰጋ መንግስቱ

የድርጅቱ ስም: በጎንደር ዩኒቨርሲቲ ህክምናና ጤና ሳይንስ ኮላጅ የህብረተሰብ ጤና አጠባበቅ ትምህርት ክፍል ወጪውን የሚሸፍነው ፡ የአማራ ብሔራዊ ክልላዊ መንግስት ጤና ጥበቃ ቢሮ

መግቢያ

ይህ የመረጃና የስምምነት ውል ቅፅ የተዘጋጀው እርስዎ ተሳታፊ እንዲሆኑ ስለተጋበዙበት በምርምር ቡድኑ የሚካሄደውን ጥናት በተመለከተ መግለጫ ለመስጠት ነው፡፡ የምርምር ፕሮጀክቱ ዋና ዓላማ ወላጆች አቅመአዳም/ህይዋን ከደረሱ ልጆቻቸዉ ጋር በስነ ተዋልዶ ዙሪያ ግልጽ ውይይትን በተመለከተ በወላጆች እና በመሰናዶ ት/ቤት ተማሪወች ላይ ጥናት ማካሄድነው:: የምርምር ቡድኑ ለዚህ ጥናት የሰለጠኑ እና ጤና ሙያ ዲፕሎማና ዲግሪ ያላቸው፣ ሱፐርቫይዘር አና ከጎንደር ዩኒቨርሲቲ አማካሪዎችን ያካተተ ነው፡፡

የተሳተፎ ሂደት፡ በወረዳዉ ወጣቶችን ከስነተዋለዶ ጤና ጋር በተያያዘ ያላቸውን ችግር ልማዎቅ ይረዳ ዘንድበዚህ ጥናት ተሳታፊ እንዲሆኑ በአክብሮት እንጠይቃለን፡፡ እርስዎ በዚህ ጥናት ለመሳተፍ ፈቃደኛ የሚሆኑ ከሆነ ተሳተፊ በመሆንዎ በጣም ደስተኞች ስንሆን እርስዎ የጥናቱን ዓላማ በግልፅ እንዲረዱ እና የስምምነት ውሉን እንዲፈርሙልን እንፈልጋለን፡፡ በዚህ መሰረትም ለመረጃ ሰብሳቢዎቹ የሚጠይቁዎትን መረጃ በመስጠት እንዲተባበሩን በአክብሮት እንጠይቃለን፡፡በህመም ወይም በሌላ ችግር ምክንያት መሳትፍ ካልቻሉ አይግደዱም፡፡በተሳታፊዎቹ የሚሰጡ መረጃዎች እና የሚገኘው ውጤት በሙሉ በምስጢራዊ

ቁጥር ዘዴ በምስጢራዊነት የሚጠበቅ ስለሆነ ማንኛውም ዓይነት ሰው እርስዎ የሰጡንን መልስ ሊያውቀው አይችልም፡፡

ሊከሰቱ የሚችሉ ስጋቶችና የምጆት መጓደሎች፡

በዚህ ጥናት መሳተፍዎ ምናልባት ጊዜዎን ሊሻማብዎ ይችል ይሆናል፡፡ ነገር ግን ዘወትር ወደዚህ ት/ቤት በሚመላለሱበት ሰዓት ንዲሁም የጥናቱ ውጤት ወደፊት በሀገራችን በስነተዋልዶ ጤና ችግር በመቀነስ ከሚሰጠው ጥቅም አንጻር ይህን ያህል አይደለም፡፡

ጥቅሞች፡

በዚህ ጥናት በመሳተፍዎ የተለየ ጥቅም አያገኙም፡፡ ነገር ግን የርስዎ በጥናቱ ላይ መሳተፍ በስነተዋልዶ ጤና ችግር ለመቀነስ የሚረዳ ሲሆን በዚህ ዙሪያ ዘዴዎችን ለመንደፍ ከፍተኛ ሚና ይጫወታል፡፡

ማካካሻ

በዚህ ጥናት በመሳተፍዎ ምንም ዓይነት ማካካሻ አይሰጥዎትም፡፡ ነገር ግን በጥናቱ በመሳተፍዎ ምስጋናችን ከፍ ያለ ነው፡፡

ምስጢር ስለመጠበቅ

የሚሰጡን መልስ ንዲሁም የጥናቱ ውጤት በሚስጥርነት ይጠበቃል፡፡ ለዚህ ጥናት የሚሰበሰበው ርስዎን የሚመለከት መረጃ በማህደር የሚቀመጥ ሲሆን ማህደሩም በርስዎ ስም ሳይሆን በተለያ ኮድ ሲቀመጥ ከዋናው ተመራማሪ በስተቀር ለማንም አይገለፅም፡፡

በጥናቱ ያለመሳተፍ መብት፡

በጥናቱ ላለመሳተፍ ከፈለጉ በዚህ ጥናት ያለመሳተፍ፣ ከአንድ በላይ እንዲሁም ሁሉንም ጥያቄዎች አለመመለስ ይችላሉ፡፡ በዚህ ጥናት ባለመሳተፍዎ ወይም በከፊል ሆነ በሙሉ ጥያቄዎችን ባለመመለስዎ በት/ቤቱ የሚያጡት አገልግሎት አይኖርም፡፡ ትምህርትዎትንም አያደናቅፍም፡፡

መረጃ ስለማግኘት

ይህ ጥናት በጎንደር ዩኒቨርሲቲ የስነ ምግባር ኮሚቴና የህብረተሰብ ጤና አጠባበቅ ትምህርት ክፍል ተከልሶ የሚ ፀድቅ ይሆናል፡፡ ማንኛውም ጥያቄ ካለዎት ከሚከተሉት ማንኛውም ሰው በሚፈልጉት ጊዜ ማነጋገር ይችላሉ፡፡

ሀ. ተሰጋ መንግስቱ፡- ዋና ተመራማሪ

ስ. ቁ **09-18-71-36-33**

ለ. ዶ/ር በሪሁን መጋቢያዉ ፡- አማካሪ

ስ. ቁ O9-18-04-60-01

ሐ. አቶ አትንኩት አላምረዉ ፡- አማካሪ

ስ. ቁ O9-11-31-35-78

Declaration

I, the undersigned, senior MPH student declare that this thesis is my original work in partial fulfillment of the requirement for the degree of masters of public health.

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Date of submission: _____

This thesis work has been submitted for examination with our approval as university advisors

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